



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

August 6, 2010

Steve Silberberger, Administrator  
Seven Oaks Community Homes - Elm  
3940 West 5th Avenue #c  
Post Falls, ID 83854

RECEIVED

AUG 18 2010

RE: Seven Oaks Community Homes - Elm, Provider #13G025

FACILITY STANDARDS

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes - Elm, which was conducted on August 4, 2010.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

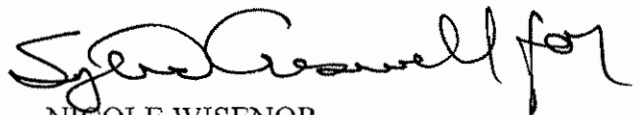
Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



JIM TROUFETTER

Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/srp  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2010  
FORM APPROVED  
OMB NO. 0938-0391

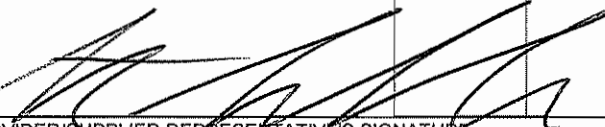
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/04/2010</b>
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NAME OF PROVIDER OR SUPPLIER

**SEVEN OAKS COMMUNITY HOMES - ELM**

STREET ADDRESS, CITY, STATE, ZIP CODE

**630 NORTH ELM STREET  
POST FALLS, ID 83854**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p><b>INITIAL COMMENTS</b></p> <p>Seven Oaks - Elm is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.</p> <p>The survey was conducted by: Jim Troutfetter, QMRP, Team Leader</p>	W 000	<p><b>RECEIVED</b></p> <p><b>AUG 18 2010</b></p> <p><b>FACILITY STANDARDS</b></p>	
		<p><i>ADMIN</i></p>		<p><i>8/12/10</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G025</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/04/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SEVEN OAKS COMMUNITY HOMES - ELM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>630 NORTH ELM STREET POST FALLS, ID 83854</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
M 000	<p>16.03.11 Initial Comments</p> <p>Seven Oaks - Elm is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)."</p> <p>The survey was conducted by: Jim Troutfetter, QMRP, Team Leader</p>	M 000			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

VOF911

If continuation sheet 1 of 1